Environmental Protection Agency
PRE / POST DEPLOYMENT EVALUATION

Medical Evaluation Form

Privacy Act Statement

The collection and use of this information is authorized by 5 U.S.C. 7901 (Health Services Programs) and 20 U.S.C 657 (Occupational Health and Safety; Record Keeping). The information will become part of your official Employee Medical File, and will be used to assist Federal Occupational Health in carrying out its occupational health services responsibilities under one or more interagency agreements with our employee agency, and for other official purposes and routine uses as described in Privacy Act systems notice OPM/GOVT-10 (Employee Medical File System Records). Providing the requested information is voluntary. Not providing the information may affect the availability and quality of health services rendered to you, and may also affect the completeness of information used by your agency in making determinations of medically-related employment decisions.

Use ONLY for EPA Employees not currently in a Medical Surveillance Program who are Deployed to Disaster Impact Zone

PRE / POST DEPLOYMENT Medical Evaluation Form

Use ONLY for EPA Employees Deployed to Disaster Impact Zone

HEALTH CENTER STAMP

Purpose of Pre/Post-Deployment Evaluation

The Pre/Post-Deployment Evaluation targets EPA employees not currently enrolled in an appropriate medical surveillance program AND who may be exposed to hazardous conditions during disaster response efforts. These employees should undergo, as soon as feasible, basic screening to document current health status, work activities or conditions, and work-related illness or injury. Workers who report repeated or prolonged hazardous exposures, injuries, symptoms or, for whom specific risk factors are identified, shall receive more comprehensive screening directed at risk factors, exposures, or adverse health effects encountered. *This is not a respirator medical evaluation.*

How Does This Work?

- **Pre-Deployment Evaluation**
  Pre-deployment assessment is designed to update employee immunizations, identify key health problems (that might complicate deployment), and collect baseline health information for comparison post-deployment.
  - EPA will distribute this form and provide a list of employees designated for deployment to FOH. Pre-deployment appointments will take ~30 minutes and can be scheduled by the employee at the designated Health Centers.
- **What makes up the Pre-Deployment Evaluation** There are 3-steps:
  - Step. #1 Employees should complete the form *(Pages 3-9)* prior to their scheduled appointment. Employee sections are color coded and clearly marked *("**EPA employee to complete**")* . Using a computer to complete the form will reduce errors, improve legibility, and allow duplicate fields to be populated automatically throughout the form.
  - Step #2. FOH nurse records vital signs, administers immunizations, and conducts indicated procedures.
  - Step #3 In Health units with a Physician or NP, the practioner reviews employee medical history and documents concerns or contraindications for deployment. The Physician or NP should complete the **BLACK** sections entitled "***Pre-Deployment Evaluation"*** *(Page 4)*, ***"Pre-Deployment Clearance"*** *(Page 10)***,** and any positive employee responses noted in the ***"Medical History"*** *(Pages 5-8)*.

    In Health units without a Physician or NP, the RN in the health unit will review form for completion of employee responses and forward completed form to the Medical Reviewing Officer (RMO). The RMO will document concerns for contraindications for deployment. The RMO should complete the **BLACK** sections entitled "***Pre-Deployment Evaluation"*** *(Page 4)*, ***"Pre-Deployment Clearance"*** *(Page 10)***,** and any positive employee responses noted in the ***"Medical History"*** *(Pages 5-8)*.
- **Record keeping**
  - In health units with Physicians or NPs, employees will be given a signed copy of their recommendation *(Page9)* at the end of their appointment. The original **Pre-Deployment Form** *(Pages 3-10)* is placed in the medical record and a copy faxed to Joe Lima at 617-565-1471. Joe Lima will notify SHEMP Managers of recommendations.
  - In health units without Physicians or NPs, the original **Pre-Deployment Form** *(Pages 3-10)* is placed in the medical record and a copy faxed to Joe Lima at 617-565-1471. Joe Lima will forward information to the RMO. Joe Lima will notify SHEMP Managers and health units of recommendations.
  - Employees are also given the **Post-Deployment Form** *(Pages 11-14)*. This form is used by the employee to document exposures during their deployment. Employee updates the Deployment Exposure History *(Page 12)* during his/her deployment. Once employee returns to home station, the employee should complete the Post-Deployment Form (Pages 11-14) and fax it to Joe Lima at 617-565-1471. The employee should save a copy for personal records.

Employee Last Name: _____

Form Revised 15Sep11

Pre-Deployment Medical Evaluation Form

Use ONLY for EPA Employees Deployed to Disaster Impact Zone

① DEMOGRAPHIC DATA *(EPA Employee to complete)*

Name (Last, First):		Date of Birth:	SS# *(### - ## - ####)*:	Sex *(M / F)*:	Work Phone *(### - ### - ####)*:
Street Address:		Supervisor Name:			Supervisor Phone *(#### - ### - ####)*:
City:	State:	SHEMP Manager:			SHEMP Manager Phone *(### - ### - ####)*:
Position Title: Div. / Br. / Sec.		Which of these Workgroups do you belong: ☐ IMT (Incident Management Team) / Field Office Staff ☐ Public Relations / Community Involvement			☐ Field Observer ☐ Other _____

② PRE-DEPLOYMENT EVALUATION *(FOH Nurse to complete)*

☐ Review of History (Pages 5-8) – Nurse should comment on all employee positive responses

☐	Vital Signs Ht _____ Wt. _____ BP _____ Pulse _____ Resp. _____	Repeat BP (if needed): _____ Date: _____ Repeat BP (if needed): _____ Date: _____	Nurse Comments:
☐	Immunization (Vaccinations needed for this deployment) Td if >10 yr *(recommended)* Hepatitis A *(optional)* Hepatitis B *(optional)*	*(circle one)* ☐ Td Given Date: _____ ☐ Hepatitis A # ❶ #❷ Date: _____ ☐ Hepatitis B # ❶ #❷ #❸ Date: _____	☐ Hep. A #❷ Date: _____ ☐ Hep. B #❷ #❸ Date: _____

If Indicated Services *(Check only if done. Complete test if employee meets indicated criteria)*

☐ Spirometry *(indicated if employee has adult asthma, SOB, or COPD)*

☐ Chest X-ray (indicated if SOB, chest pain, or positive respiratory history)
☐ EKG *(indicated if SOB, chest pain, or positive cardiac history)*
☐ FOH Panel *(indicated if positive history of metabolic disease (e.g., diabetes))*

Results of Indicated Services (*Check when completed*)
Abnormal results must be reviewed by Medical Reviewer

Spirometry: Actual in liters	FVC	FEV 1	FEV1/FVC	FEF25-75
% Predicted				

Spirometry Results:	☐ Normal	☐ Abnormal
Chest X-ray Results:	☐ Normal	☐ Abnormal
EKG Results:	☐ Normal	☐ Abnormal
FOH Panel:	☐ Normal	☐ Abnormal

③ SOCIAL HISTORY *(EPA Employee to complete)*

Employee Last Name: _____

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Smoking History

Smoking increases your risk for lung cancer and other types of cancer, bronchitis, emphysema, asbestos-related lung diseases, coronary heart disease, high blood pressure, and stroke. (*Check All that apply.*)

☐ Never Smoked

☐ Current / Former Smoker

Are you still smoking? ☐ Yes ☐ No

# of cigarettes per day _____ pks/day

# of cigars per day _____

# of Pipe bowls per day _____

Total years smoked _____

# of years since you quit _____ (Former smokers only)

Nurse Smoking Comments *(Optional)*:

Alcohol/Drug Use *(Complete question and check all that apply)*

What is your average alcohol use? _____ drinks per week

(1 drink = 12 oz beer, 1 glass wine, or 1.5 oz liquor)

How often do you drink alcohol? ☐ Weekdays ☐ Weekends ☐ Both

Do you use recreational drugs? ☐ Currently ☐ Previously ☐ Never

Nurse Alcohol/Drug Comments *(Optional)*:

④ MEDICATION / ALLERGIES / HOSPITALIZATIONS *(EPA Employee to complete)*

List Current Medications:

List Current Medication Allergies:

List Hospitalization in the last two years:

⑤ MEDICAL HISTORY *(EPA Employee to complete)*

Vision	Yes	No	*Nurses should be brief but document enough information to determine if the reported problem will prevent deployment or require work*

Employee Last Name: _____

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			limitations
Frequent headaches?	☐	☐	**Vision Comments** ***(Required on all positives)*** *Are headaches so frequent or severe that the employee has to limit activity? Do they disrupt vision so the employee could not drive or operate machinery safely? Does the employee know what disease he has or what is causing the problem? Is it mild, moderate, or severe? Does it prevent him/her from doing routine activities safely (e.g., driving, reading in low light, reading traffic lights)? Are there any residual complications from past eye surgery (halos, can't drive at night, etc.)?*
Unexplained blurred vision?	☐	☐	
Known eye disease?	☐	☐	
Difficulty reading?	☐	☐	
Colorblindness?	☐	☐	
Do you wear eye glasses?	☐	☐	
Do you wear contacts	☐	☐	
Have you had surgery to correct nearsightedness?	☐	☐	
Hearing	**Yes**	**No**	*Nurses should be brief but document enough information to determine if the reported problem will prevent deployment or require work limitations.*
Ringing in ear?	☐	☐	**Hearing Comments** ***(Required on all positives)*** *Does the employee's problem prevent him from hearing a telephone or warning ("Hey, watch out!")? Hearing aid used? Describe dizziness or balance problems. When does it occur, what brings it on, and how bad is it (does it cause the employee to stop what he/she is doing?) Is there anything that would keep the employee from flying or diving (ear infection?). Is the employee currently exposed to noise hazards at home or work? Is protection used (25%, 50%, 75,%, or 100% of the time)?*
Difficulty hearing?	☐	☐	
Dizziness / Balance problems?	☐	☐	
Current ear infection / cold?	☐	☐	
Are you in a hearing conservation program?	☐	☐	
Do you use hearing protection?	☐	☐	
Heart / Cardiovascular	**Yes**	**No**	*Nurses should be brief but document enough information to determine if the reported problem will prevent deployment or require work limitations*
Angina (heart pain)?	☐	☐	**Heart/Cardiovascular Comments** ***(Required on all positives)*** *Angina / Palpitations: What causes it to occur? What t relieves it? How often does it occur? Does it cause SOB / dizziness / loss of consciousness? Heart Attack: When did it occur? Treatment? Last EST? Limits on exercise or work restriction? Heart Disease: Blood thinners?*
Irreg. heart beat / palpitations?	☐	☐	
History of heart attack?	☐	☐	
Organic heart disease (prosthetic heart valves, heart block, pacemaker, etc.) ?	☐	☐	
Past heart surgery?	☐	☐	

Employee Last Name: _____

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⑤ MEDICAL HISTORY *(EPA Employee to complete)*

Lungs / Respiratory	Yes	No	*Nurses should be brief but document enough information to determine if the reported problem will prevent deployment or require work limitations.*
Asthma?	☐	☐	**Lung / Respiratory Comments** ***(Required on all positives)*** *Is the employee's asthma well controlled? When was last hospitalization due to asthma? When was last attack? What triggers attacks? How often does employee use an inhaler? Sinus Infection: When did employee have last infection? How was it treated? Any residual or exposures their physician has advised them to avoid? TB: When diagnosed? How treated? Did they complete treatment? Any current Symptoms?*
Bronchitis?	☐	☐	
Acute / Chronic lung infection?	☐	☐	
Allergic sinusitis / rhinitis?	☐	☐	
Collapsed lung?	☐	☐	
Scoliosis (curved spine) with breathing limitations)?	☐	☐	
History of tuberculosis?	☐	☐	

Vascular	Yes	No	*Nurses should be brief but document enough information to determine if the reported problem will prevent deployment or require work limitations.*
High blood pressure?	☐	☐	**Vascular Comments** ***(Required on all positives)*** *HTN: When diagnosed? On medication? Does he/she take her medication? Is blood pressure well controlled? Varicose Veins: History of blood clots? Leg pain? White Finger? When diagnosed? How often does this occur? How do they control or prevent it? What triggers it (cold, vibrating equipment, etc.? CVA/TIA: When it occurred? How treated? Describe residual impairments and limitations (weakness left leg can't climb ladder/drive car without modifications)?*
Varicose Veins?	☐	☐	
Poor circulation hands/feet?	☐	☐	
White finger (cold/vibration)	☐	☐	
Stroke / TIA?	☐	☐	
Aneurysm?	☐	☐	

Musculoskeletal	Yes	No	*Nurses should be brief but document enough information to determine if the reported problem will prevent deployment or require work limitations.*
Amputations?	☐	☐	**Musculoskeletal Comments** ***(Required on all positives)*** *If they lost limb, what can't they do (e.g., jump, climb, task that require good balance, etc). Chronic conditions should be described as mild, moderate, or severe. Does it prevent the employee from doing any "recreational" or "work" activity? Are there any current activity limitations from the employee's physician?*
Loss of use of arm/leg/hand?	☐	☐	
Moderate to severe arthritis?	☐	☐	
Moderate to severe tendonitis?	☐	☐	
Chronic back pain if associated with pain radiating down leg or leg weakness?	☐	☐	
Unstable shoulder / knee/ankle?	☐	☐	

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⑤ MEDICAL HISTORY *(EPA Employee to complete)*

Gastrointestinal	Yes	No	*Nurses should be brief but document enough information to determine if the reported problem will prevent deployment or require work limitations*
Hiatal hernia / Severe reflux?	☐	☐	**Gastrointestinal Comments *(Required on all positives)*** *For deployments diets cannot be generally well controlled. Employees who need to maintain a strict control of their diet because of their medical condition may not be candidates for deployment. Reflux: Is the condition stable or uncontrolled? Hernia: Type? Has it been repaired? Is there a lifting restriction? Bleeding: What caused it? Is it corrected? Last episode? Dizziness/loss of consciousness?*
Diverticulitis?	☐	☐	
Hernia?	☐	☐	
Colostomy?	☐	☐	
Hepatitis?	☐	☐	
Ulcer?	☐	☐	
Bleeding (Rectal / Vomiting)?	☐	☐	
Irritable bowel syndrome?	☐	☐	
Bowel obstruction?	☐	☐	

Genitourinary	Yes	No	*Nurses should be brief but document enough information to determine if the reported problem will prevent deployment or require work limitations.*
Blood in urine?	☐	☐	**Genitourinary Comments *(Required on all positives)*** *For deployments, access to toilet facilities may not be readily available. Frequency and urgency should be discussed.*
Difficult or painful urination?	☐	☐	
Infertility *(difficulty having children)?*	☐	☐	

Neurological	Yes	No	*Nurses should be brief but document enough information to determine if the reported problem will prevent deployment or require work limitations*
Seizures	☐	☐	**Neurological Comments *(Required on all positives)*** *Stress with long irregular work hours may exacerbate seizures or migraines. Sz: Type (grand mal?) How frequently to they occur? Triggers? Insomnia: Cause (situational, environmental, dietary (caffeine)? Has it been evaluated? Daytime sleepiness? Neurological Disease: What is it? When Diagnosed? Tx'ment? Any physical or mental deficits?*
Loss of memory	☐	☐	
Migraine	☐	☐	
Trouble sleeping *(persistent)*	☐	☐	
Numbness/tingling	☐	☐	
Head/Spine surgery	☐	☐	
Any neurological disease	☐	☐	
Head trauma *(persistent deficit)*	☐	☐	

Employee Last Name: _____

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⑤ MEDICAL HISTORY *(EPA Employee to complete)*

Psychiatric	Yes	No
Depression	☐	☐
Stress / Anxiety / Panic attacks	☐	☐
Bipolar disorder	☐	☐
Neurosis / Hysteria *(circle one)*	☐	☐
Obsessive/Compulsive disorder	☐	☐
Hospitalized for psychiatric disease	☐	☐
Taken medication for treat mental disorder	☐	☐

Nurses should be brief but document enough information to determine if the reported problem will prevent deployment or require work limitations.

Psychiatric Comments ***(Required on all positives)***

Stress with long irregular work hours may exacerbate psychiatric conditions. Is condition well controlled? Last exacerbation? Triggers?

⑥ PHYSICAL & ENVIRONMENTAL HAZARD *(EPA Employee to complete)*

Have you experienced?

☐ Latex Allergy ☐ Skin Cancer
☐ Animal Protein Allergy ☐ Back Problems ☐ Hypothermia / Cold Injury
☐ Mold/Mildew Allergy ☐ Lyme Disease ☐ Hyperthermia / Heat Injury
☐ Chronic Fatigue ☐ Vibration effects ☐ Adverse Effects from Confined Space ☐ Health Effects from Hazardous Waste

Nurse Physical/Environmental Hx Comments *(Required for all positives)*

Employee Last Name: _____

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⑦ PHYSICAL ACTIVTY / EXERCISE HISTORY *(EPA Employee to complete)*

Intensity (check one): ☐ Low ☐ Moderate ☐ High

Activity Type: _____ (walking, biking, jogging, etc.)
Frequency: _____ days per week
Duration: _____ minutes per session

Employee Comments *(Optional)*

⑧ OCCUPATIONAL HISTORY *(EPA Employee to complete)*

Description of Duties in Current Job: _____

Functional Activities *(Current position):*
☐ Heavy Lifting (>40lbs) ☐ Walking ____ hrs/day ☐ Standing ____ hrs/day
☐ Climbing ☐ Operation of motor vehicle ☐ Crawling ☐ Diving

Usual Exposures *(Current position):*
Check all that apply
☐ Dust ☐ Fumes ☐ Pesticides ☐ Gases ☐ Radiation
☐ Asbestos ☐ Noise ☐ Vibrations ☐ Confined space ☐ Sewage
☐ Heavy metal ☐ Chemicals ☐ Temperature extremes

Previous Adverse Health Effects **P**ossibly Related to the Job? *(Describe)***:**

Other Work Performed? *(e.g., Moonlighting, hobbies, etc.)*: _____

Any Other Exposure to Hazardous Material? *(Describe)* _____

Work History:

How long have you been doing this type of work? _____ Years

Have you ever been off work more than a day because of work-related illness/injury *(Check one)*? ☐ No ☐ Yes If yes, describe:

Have you ever changed jobs or duties due to health problem? ☐ No ☐ Yes If yes, describe:

Pre-Deployment Medical Evaluation Form

Use ONLY for EPA Employees Deployed to Disaster Impact Zone

⑨ **PRE-DEPLOYMENT CLEARANCE** *(EPA Employee completes)*			
Employee Name (Last, First):	SSN *(### - ## - ####*):	Position Title:	Work Phone *(### - ### - ####)*:
Supervisor Name:	Supervisor Position Title: Div. / Br. / Sec.	Supervisor Phone *(#### - ### - ####):*	FOR FOH USE ONLY FOH Health Center *(Health Ctr. Stamp)*
SHEMP Manager Name:	SHEMP Manager Phone *(#### - ### - ####):*	SHEMP Manager FAX *(#### - ### - ####):*	
SHEMP Manager Address (RM #, Street, City, State):			

NOTE: This clearance page is sent to your SHEMP Manager. Make sure your SHEMP Manager's Fax OR mailing address is included on this form.

Pre-Deployment Medical Clearance Statement *(FOH Nurse or Medical Reviewer completes)*

In my opinion, the above employee is:

- ☐ **CLEARED for deployment as directed by standing orders** *(Expires one year from review date)*
- ☐ **DEFERED. Further evaluation, as described below, is needed before a deployment decision can be made.**
- ☐ **NOT MEDICALLY QUALIFIED for deployment**
- ☐ **CLEARED WITH LIMITATIONS**

Recommended Limitations or Evaluation needed

_____

_____

_____

The employer should call the Health Center (see above contact information) if they want to complete the recommended evaluation.

Nursing / Medical Provider Signature: _____ **Review Date:** _____

Printed Name:_____

Post-Deployment Form Starts Here

- Employee should use this portion of the form to track exposures during their deployment
- Once you return to your home base, complete any missing information and fax this post-deployment form to Joe Lima at 617-565-1471. Keep & file copy for your records.
    - Your record will be reviewed and filed for future reference.
    - If you developed significant problems during your deployment, you will receive a follow-up call.

Contact Information:

Joseph Lima
Account Manager Assistant
Federal Occupational Health
JFK Building, Room E-110
25 New Sudbury Street
Government Center
Boston, MA 02203
617-565-3062 (Voice)
617-565-1471(Fax)

Employee Last Name: _____

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Disaster Impact Zone Post-Deployment Medical Evaluation Form

① DEMOGRAPHIC DATA *(EPA Employee to complete)*

Name (Last, First): ,	Date of Birth:	SS# *(### - ## - ####)*:	Sex *(M / F)*:	Work Phone *(### - ### - ####)*:
Street Address:	Supervisor Name:			Supervisor Phone *(#### - ### - ####)*:
City: State:	SHEMP Manager:			SHEMP Manager Phone *(### - ### - ####)*:
Position Title: — Div. / Br. / Sec.	Which of these Workgroups do you belong: ☐ IMT (Incident Management Team) / Field Office Staff ☐ Field Observer ☐ Public Relations / Community Involvement ☐ Other _____			

② POST-DEPLOYMENT EXPOSURE HISTORY *(EPA Employee to complete)*

Use this form to track your duty assignments and possible exposure during your deployment. Make a copy of this page if you run out of room.

Site: *(State / City / County / Site) if available include EPA Identifier #*	**Date:** *# Days Inclusive dates onsite*	**Specific Chemical and Physical Factors** *Chemicals at site, if known*	**Exposure Level** *Low - High*	**Level of PPE** *Level A/B/C/D None*	**Symptoms from Exposure**	**Job Duties**
SAMPLE						
#1						
#2						
#3						
#4						
#5						

Employee Last Name: _____

Form Revised 15Sep11

Disaster Impact Zone Post-Deployment Medical Evaluation Form

③ POST-DEPLOYMENT QUESTIONAIRE *(EPA Employee to complete)*

#1 Did your health change during this deployment?

- ☐ Health stayed about the same
- ☐ Health got worse

#2 How many times were you seen for medical evaluation during this deployment?

_____ times

#3 Did you have to spend one or more nights in a hospital as a patient during this deployment?

☐ No ☐ Yes, Reason / Dates _____

#4 Did you receive any vaccinations just before or during this deployment?

☐ No ☐ Yes, Reason / Date _____

While you were deployed were you exposed to *(circle all that apply) Y=Yes, N=No, NC=Not Certain:*

Y N NC	Chemicals	Y N NC	Fatigue
Y N NC	Traumatic Incident Stress	Y N NC	PPE
Y N NC	Heat Stress	Y N NC	Solvents
Y N NC	Ultraviolet Radiation	Y N NC	Sand/dust
Y N NC	Petroleum Products	Y N NC	Dispersants
Y N NC	Odors		

#6 Do you have any of these symptoms now, or did you develop them anytime during this deployment?

☐ Chronic Cough	☐ Runny nose	☐ Difficulty breathing
☐ Fever	☐ Weakness	☐ Back pain
☐ Headaches	☐ Muscle aches	☐ Chest pain
☐ Rash/Skin disease	☐ Ringing in ears	☐ Still tired after sleeping
☐ Dimming of vision	☐ Dizziness/fainting	☐ Difficulty remembering
☐ Anger/Irritability	☐ Vomiting/Diarrhea	☐ Frequent indigestion
☐ Swollen stiff / painful joints		☐ Numbness/tingling hands

#7 During his deployment did you ever feel that you were in danger?

☐ No ☐ Yes, Reason / Dates _____

#8 Are you currently interested in receiving help for stress, emotional alcohol or family problems?

☐ No ☐ Yes, Reason / Dates _____

#9 Did you experience anything during this deployment that was so upsetting that you:

- ☐ Are having nightmares?
- ☐ Avoiding situations that remind you of it
- ☐ Are constantly watchful or easily startled
- ☐ Feel numb or detached from others.

Medical Reviewer Notes:

Employee Last Name: _____

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Disaster Impact Zone Post-Deployment Medical Evaluation Form

④ DEMOGRAPHIC DATA *(EPA Employee to complete)*

Employee Name (Last, First):	SSN *(### - ## - ####)*:	Position Title:	Work Phone *(### - ### - ####)*:
Supervisor Name:	Supervisor Position Title: Div. / Br. / Sec.	Supervisor Phone *(#### - ### - ####)*:	FOR FOH USE ONLY FOH Health Center *(Health Ctr. Stamp)*
SHEMP Manager Name:	SHEMP Manager Phone *(#### - ### - ####)*:	SHEMP Manager FAX *(#### - ### - ####)*:	
# of Disaster Deployments this year: *(Circle one)* #1 #2 #3 #4 #5	SHEMP Manager Address (Room #, Street, City, State):		

NOTE: This clearance page is sent to your SHEMP Manager. Make sure your SHEMP Manager's Fax OR mailing address is included on this form.

Post-Deployment Medical Referral *(FOH Nurse or Medical Reviewer completes)*

I have reviewed the Pre/Post-Deployment information provided by the above employee. As a result of this information:

- ☐ **NO ADDITIONAL Follow Up is needed.** Pre/Post-Deployment forms have been filed in the medical record.
- ☐ **REFERRAL IS NEEDED. Further evaluation, as described below, is needed to evaluate a possible work-related exposure.**
- ☐ **WORK LIMITATIONS ARE NEEDED.**

The following work limitations or referral is recommended:

_____

_____

_____

The employer should call Wayne Grant at (816) 926-7700 if they need assistance if arranging the recommended evaluation.

Medical Reviewer Signature: _____ **Review Date:** _____

Printed Name:_____